BOSTON HEALTH CARE *for* *the* HOMELESS PROGRAM

December 20, 2016

David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

Dear Mr. Seltz:

I am pleased to offer comments on the 2017 Data Submission Manual (DSM) recently proposed by the Health Policy Commission (HPC), which establishes the data elements that Registered Provider Organizations (RPOs) will submit to satisfy their 2017 Registration Renewal with the HPC (958 CMR 6.05(5)) and 2017 filing requirements with CHIA (957 CMR 11.00). Boston Health Care for the Homeless Program (BHCHP) is a not-for-profit Community Health Center providing high-quality health care to homeless men, women, and children in the greater Boston area.

Criteria for Abbreviated Filings

Our main concern with this regulation, in its current form, is that—taken together with the reporting regulation recently proposed by CHIA—the requirements are not tiered adequately by provider size and scope of risk-based contracts. We believe that the HPC and CHIA, in thoughtfully and jointly crafting the RPO program requirements, are aiming to reduce administrative burden on providers while focusing on practices of a significant size. Boston Health Care for the Homeless Program has no reportable contracting affiliations, clinical affiliations, or acute care hospitals. It currently has no contracts involving downside risk. Its organizational structure is comprised of a single entity: the community health center, Boston Health Care for the Homeless Program. And it just barely met the financial threshold for reporting at all—and only when including its pharmacy revenue in the calculation of Net Patient Services Revenue. Yet, because BHCHP negotiates its own contracts with payers, it is ineligible for an abbreviated application and is required to fulfill the same reporting requirements as major health care systems comprised of much more complex corporate networks that include acute care hospitals.

Our suggestion is not that organizations like BHCHP should be exempted from this program, but that the criteria for an abbreviated application be revised to better reflect the broad range in size and complexity of, the financial risk assumed by, and the reporting capacity available to the provider organizations across the state. Reporting requirements with the HPC, to date, have been manageable for smaller providers like BHCHP precisely because the entities for which we must report are limited, but when layered with CHIA's proposed reporting—including, now or in future years, reporting on utilization, clinical quality, care coordination, and more comprehensive financial reporting (957 CMR 11.03(1)(d), 11.03(1)(e), 11.03(1)(g), and 11.03(1)(h))—the resources required to analyze, track and report on these requirements become more significant. We agree that these are critical topics to examine, and we continue to be committed to developing our capacity to explore them in more detail.

But when combined with the evolving requirements of other health reform programs, we are concerned that small, community-based health care organizations like ours may lack the administrative resources to adequately meet these reporting requirements, and patient care may be impacted.

Reporting Timeframes
You specifically sought feedback on new timeframes. While it is not impossible for us to report on relationships as of a certain date (e.g., 1/1/2017), it does add to reporting complexity. It is our recommendation that reporting is required to be accurate as of the date of filing, and that different parts of the filing should not each have different reporting timeframes. The filing requirements—particularly because they span two programs—are already complex enough.

Updated Organization Types and Available Services
The proposed changes to RPO-53 and RPO-87 seem reasonable.

Reporting Threshold for Small Physician Practices
The proposed threshold regarding Provider Organizations' contracting affiliates with physician practices that include fewer than five physicians seems helpful to reduce administrative burden on Provider Organizations with large contracting networks which include a significant number of one and two-physician practices. It is right to "focus on physician practices of a significant size for which the Commonwealth values having detailed data." Yet small Provider Organizations with limited resources should also be protected. See earlier comment on abbreviated filings.

EIN Removal
The HPC proposes to remove EINs from the physician roster and instead collect physician license numbers. This seems acceptable.

APM and Other Revenue File
We do not have concerns at this time about completing this exhibit. We anticipate being able to submit the CY2015 data by the proposed filing date of Summer 2017.

A final comment is that, with the advent of Medicaid ACOs, we hope that the DSM will clearly instruct providers like BHCHP who have contracted with an ACO but who are not formally part of the ACO. We appreciate the opportunity to provide these suggestions as you seek to finalize a registration and reporting program that will increase provider transparency across the state. We have shared similar comments with CHIA in response to their draft regulation. Please do not hesitate to contact me directly if you have further questions concerning our responses. I can be reached via email at bbock@bhchp.org or by phone at 857-654-1015.

Sincerely,

Barry Bock

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